Gazewood & Weiner
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1008 16th Ave. Ste. 200
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(907) 452-5196 of FAX (907) 456-7058
(907) 452-4255 or FAX (907) 456-1480
Email: info@fairbankslaw.com

FACSIMILE TRANSMITTAL COVER SHEET

****

IMPORTANT MESSAGE

DATE: 17May11

TIME: 11:01 AM/PM

TO: AK Teamster-Employer Service Corp. Attn: Dennie Castillo

FAX NUMBER: 907-565-8338

REPLY REQUESTED: ☒ YES

☐ NO

NUMBER OF PAGES TO FOLLOW (Cover page plus): 2

MESSAGE: Re: Justin Olsen

SENDER'S NAME: Yauna Taylor

IF YOU DO NOT RECEIVE ALL PAGES OF THIS TRANSMITTAL, CALL THE ABOVE SENDER IMMEDIATELY AT (907) 452-4255.

EXHIBIT 13
Page 1 of 4

GAZEWOOD & WEINER
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1008 16th Avenue, Suite 200
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Facsimile: (907) 456-7058

Jason A. Gazewood
Jason A. Weiner

Shannon T. Morgan
JB Brainerd
Kristin Farleigh

VIA FACSIMILE ONLY (907) 565-8338

May 17, 2011

Alaska Teamster-Employer Welfare Trust
520 East 34th Ave., Ste. 107
Anchorage, AK 99503-4116

ATTENTION: DENNIE CASTILLO

Dear Dennie:

This letter is to follow up with our telephone conversation last week regarding records of Justin Olsen. Mr. Olsen has retained Jason A. Weiner to represent him regarding the denial of his medical benefits.

I have attached the Request for Authorization that you requested in order to release these records to our office.

Please provide us with any documents pertaining to Mr. Olsen's denial and subsequent appeal(s).

If you need anything else from us, please do not hesitate to contact me at (907) 452-5196 or by email at ytaylor@fairbanksaklaw.com.

Thank you for your prompt attention in this matter.

Sincerely,

Yauna Taylor
Paralegal

EXHIBIT 13
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Medical Authorization to Disclose Health Information
(Medical Records Release Form) - HIPAA Patient Authorization to Use/Disclose

TO: Alaska Teamster-Employer Service Corporation

I, Justin Olsen, DOB: 6-17-82, SSN: 574-72-3179 hereby authorize the above medical care provider, to release confidential health information and documents to:

Gazewood & Weiner
1008 16th Ave., Ste 200
Fairbanks, Alaska 99701
(907)452-5196

or any person employed on its behalf. This authorization is for legal purposes.
I specifically authorize the disclosure of the following health information and records:

- [X] Copies of any document, records, or other information that:
  was relied upon in making a decision to deny benefits;
  was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits;
- [X] demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the Plan and that Plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals.

I. JO **(initial)** I acknowledge, and hereby consent to such, that the release information may contain alcohol, drug abuse, psychiatric, psychosocial, HIV testing, HIV results or AIDS information.

II. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or eligibility for treatment. I may inspect or copy records disclosed with this authorization.

III. I understand that if the person or entity receiving this information is not a health care provider covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

IV. I understand I have a right to revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **GAZEWOOD & WEINER,** whose address is listed above. I understand the revocation will not apply to information that has already been released in response to this authorization.

V. I understand that under Alaska law, **GAZEWOOD & WEINER,** or persons employed on its behalf, is permitted to discuss my medical condition (including contents of medical, psychological, or psychotherapy records) with my physicians. [Langdon v. Champion, 745 P.2d 1371, 1374 (Alaska 1987)]. It is within the discretion of your physician whether the physician wishes to participate in such discussions.

VI. This authorization expires 360 days (12 months) from the signature date below.

Signature: Justin T. Olsen Date: 12 May 2011
Address: 1075 Adventure Dr North Pole AK 99705 Phone Number: (907) 490 2417

SUBSCRIBED & SWORN TO BEFORE ME this 12 day of May, 2010.

Jason R. Weiner NOTARY PUBLIC STATE OF ALASKA

Notary Public in and for Alaska
My Commission Expires: 1/16/2013

This release pertains to medical information, which is protected by both State and Federal Law including the Health Insurance Portability and Accountability Act (HIPAA). Any other use is forbidden. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that reading, disseminating, disclosing, distributing, copying, acting upon or otherwise using this information is strictly prohibited. If you have received this information in error, please notify sender immediately. You will be notified at that time how to dispense the records.

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TRANSMISSION VERIFICATION REPORT

TIME : 05/17/2011 11:06
NAME :
FAX :
TEL :
SER.# : D0J384668

DATE,TIME	05/17 11:06
FAX NO./NAME	19075658338-02826
DURATION	00:00:45
PAGE(S)	03
RESULT	OK
MODE	STANDARD ECM

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